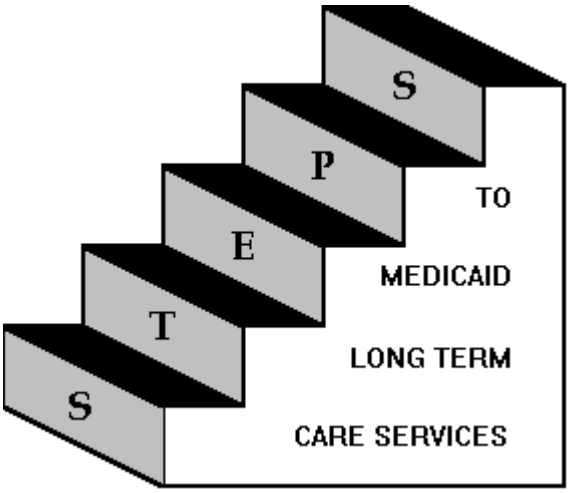

DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Long Term Care Medicaid

www.dhss.delaware.gov/dhss/dmma/

Form 480 (Rev. 1/2012) Document #350701-02-02-05

As life's circumstances change, an individual may find it necessary to seek assistance in paying for long-term care services. Two government plans that may help pay for long-term care services are Medicaid and Medicare. Private insurance may also cover long-term care services.

This guide provides general information about Long Term Care Medicaid policy and program requirements. It includes information regarding Federal law and the laws of the State of Delaware. Relevant law may change from year to year, so be sure you have the most recent edition of this guide. The information provided should be used in conjunction with information you receive during your Medicaid application interview. You should always consult local Medicaid offices to supplement and verify the information contained in the following pages.

What are some differences between Medicare and Medicaid?

Medicare	**Medicaid**
A health insurance program that individuals receive when they get Social Security.	A health insurance program that individuals may receive based on medical and financial need.
Will cover nursing facility care for someone who requires a skilled level of care and has been placed in a Medicare-certified nursing facility bed after a 3-day hospital stay.	Will cover nursing facility care for someone who requires a skilled or intermediate level of care and is placed in a Medicaid-certified nursing facility bed or home care placement.
Does not cover long-term nursing facility care. Coverage is only for a limited number of days.	Medicaid will pay for nursing facility care or home care as long as the resident remains medically and financially eligible for Medicaid.

What services are available in Delaware for long term care coverage?

If an individual is a resident of Delaware and meets the medical and financial eligibility requirements, the Delaware Division of Medicaid & Medical Assistance can pay for long-term care services through the following Medicaid Programs:

1. Nursing Facility Program
2. Long Term Care Community Services (HCBS)
   Elderly and Disabled/Assisted Living/Acquired Brain Injury
   AIDS/HIV Community-Based Services
3. Developmental Disabilities Services Waiver
4. Program of All-Inclusive Care for the Elderly (PACE)
   Expected in Fall of 2012 in New Castle County

The majority of the Medicaid population receiving Medicaid services will be enrolled into the Diamond State Health Plan, or Diamond State Health Plan Plus. Individuals that are eligible for the Nursing Facility Program, the Long Term Care Community Services Program (Elderly & Disabled/Acquired Brain Injury/Assisted Living and Aids/HIV services) must enroll in Diamond State Health Plan Plus. This managed care initiative will provide improved access to community-based long-term care services, increased flexibility to more effectively address individual needs, and to better control rising long-term care costs significantly impacting Medicaid.

Individuals that opt for enrollment in the Program of All-Inclusive Care for the Elderly (PACE) are not eligible to enroll in a Managed Care.

Please use the following space to make notes and or questions that you may have regarding the Long Term Care Community Services Program.

Notes/Questions:

Long Term Care Programs

1. Nursing Facility Program

- This program pays for the cost of care in nursing facilities in Delaware that have contracts with the Managed Care Organizations. These nursing facilities provide room, board, and nursing services to persons who are elderly or disabled. An individual applying for the Nursing Facility Program must be in need of a skilled or intermediate level of care as defined by Delaware Medicaid criteria. In other words, the individual must require the level of care provided by a nursing facility.

- A nursing facility resident receiving Medicaid may keep $44.00 of his/her monthly income. The rest of his/her income must be paid to the facility unless an amount is needed for (1) health insurance premiums, (2) medically necessary medical equipment and services not covered by Medicaid (e.g. eye glasses, dentures, hearings aids), (3) the needs of a community spouse under the **Spousal Impoverishment** provision or a home maintenance allowance, and/or (4) dependent family member allowance.

- If a patient in a Medicaid enrolled nursing facility runs out of private funds and becomes eligible for Medicaid payment, the nursing facility cannot discharge him/her if there is an available Medicaid certified bed.

- Some beds in a Nursing Facility may not be Medicaid certified. If resident is not in a Medicaid certified bed, Medicaid cannot pay for that resident's care.

- Federal law prohibits nursing facilities from charging Medicaid recipients or their families for items and/or services that are covered by Medicaid.

- Nursing facilities that accept Medicaid cannot ask Medicaid recipients for contributions as a condition of admission or charge fees to supplement the Medicaid rate.

- Nursing facilities must provide a list of what items and services are included in the basic Medicaid rate, and what items or services would require an extra charge. Individual may also obtain a list of what Medicaid pays for and what the nursing facility is required to supply from the Division of Medicaid & Medical Assistance.

Considerations for Selecting a Nursing Facility

The Division of Long Term Care Resident Protection (DLTCRP) licenses and certifies Medicaid enrolled nursing facilities. DLTCRP issues survey reports to the facilities after each annual and complaint/incident survey. You may obtain a copy of a facility's survey report by contacting the Division's New Castle County office.

Division of Long Term Care Resident Protection
3 Mill Road, Suite 308
Wilmington, DE 19806-2164
Phone: (302) 577-6661
Fax: (302) 577-6672 & 6673

You can also call a facility to schedule a tour. Visit a second time on the weekends or in the evening when some nursing facilities have less staff. Spend time talking to the residents and staff. Ask questions.

? Ask about access to medical services and arrangements for handling emergencies.

? Are the residents out of their beds during the day? Are they dressed appropriately for the season and time of day?

? Are there a variety of activities? Are there social functions and religious services?

? Is the dining room pleasant? Is the food good, the right temperature, and nutritious? Are snacks available?

? Does the staff address residents by name?

? Does the staff respond quickly to resident calls for assistance?

? Is rehabilitative care available routinely to residents who need it?

? Is the nursing facility designed for the needs of older people? Are call buttons in bedrooms and bathrooms? Are there wide doorways and ramps? Are there hand rails where necessary? Is the furniture easy to maneuver around and use?

? Are personal mail and documents respected? Are personal possessions safe?

? Does the facility have an unpleasant odor?

Visits from family and friends are very beneficial to any nursing facility resident. Visits not only offer reassurance to the resident that someone still cares, but those residents whose families and friends are actively involved with them usually have a better outlook on life which contributes to better health.

2. Long Term Care Community Services Program

This program provides individuals who qualify for the Medicaid Nursing Facility program with an alternative to going into a nursing facility. An individual applying for this program requires a skilled or intermediate level of care as defined by Delaware Medicaid criteria. An individual that has been diagnosed with AIDS or are HIV positive with two associated symptoms and require a hospital level of care may also be eligible.

This program allows an individual to remain in his/her own home or an Assisted Living facility comfortably and safely by providing special community-based services. Those who are eligible for this program can receive, as needed, all regular Medicaid services and also additional services that Medicaid normally does not cover. These special services include:

- **Case Management** – A case manager is available to help with identifying and obtaining the services necessary for the individual to remain in his/her home comfortably and safely.

- **Personal Care Services**– An aide will help with personal care such as bathing and dressing, and can also help with household chores such as light housekeeping and laundry.

- **Medical and Social Day Care** – For this service, an individual goes to a Day Care Center during the day near where they live. The staff there would provide meals and snacks, nursing services, supervision and recreational and or medical therapy.

- **Respite Care** – This service allows an individual to have an aide come to his/her home to take care of him/her for short periods of time when the primary caregiver has to be away from the home. Short-term respite care in a nursing facility is also available.

- **Emergency Response System –** This is a mechanical device that is worn clipped to clothing or on a cord around the neck. If an individual falls and cannot get up, or if there is a fire or other emergency, there is a button that signals the police and fire company that help is needed when pressed.

- **Cognitive Services -** For individuals with Acquired Brain Injury. Assist in the diagnosis and treatment of certain problems that can result from brain injury. Cognitive services include: 1) an assessment to find out a person's needs; and 2) behavioral therapy.

- **Assisted Living -** a residential care option that provides support to residents in a homelike setting. Support usually includes personal services and light medical or nursing care. Assisted living allows residents more independence than nursing home care.

- **Mental Health Services** – This service consisting of treatment, rehabilitation, and support, is designed to assist clients in maintaining life in the community, obtain relief from AIDS-related psychiatric and neurological symptoms, receive appropriate psychiatric and substance abuse treatment services, and benefit from self-help support groups. Services are provided by specially qualified clinicians who have received advanced clinical AIDS training. Services include one or more of the following: psychiatric evaluation, psycho-social assessment, individual counseling/psycho-educational services.

- **Supplemental Nutrition** – This service is to be routinely considered for individuals diagnosed with HIV/AIDS to ensure proper treatment in individuals experiencing weight loss, wasting, malabsorption and malnutrition. Oral nutrition supplements are offered as a service to individuals who meet AIDS Waiver requirements and who are at nutritional risk.

Please note: This program does not arrange for or pay housing or other living expenses.

Notes/Questions:

3. Developmental Disabilities Services Waiver

This program is operated by the Division of Developmental Disabilities Services (DDDS). An individual applying for this program must be in need of an intermediate level of care for persons with mental retardation.

This program provides individuals who qualify for the Medicaid nursing facility program with the alternative of living in the community by providing special community-based services. Those who are eligible for this program can receive Medicaid services that are outlined in the State Plan and in addition they may receive:

- **Case Management** – The DDDS case manager helps the individual determine and obtain services that are needed to promote a safe environment in the community.

- **Habilitation Services** – Specialized training and supervision provided in certain residential settings. These are group homes, Adult Family Living Homes and Foster Training homes, Neighborhood homes, Supervised Apartments, and Staffed Apartments.

- **Prevocational Services-** are aimed at preparing individuals for paid or unpaid employment. These are not task oriented. They are provided to individuals who are not expected to join the general workforce.

- **Supported Employment Services** – enable individuals to engage in paid work in a variety of settings in which persons without disabilities are normally employed.

- **Day Habilitation Services** – enable individuals to attain their maximum functioning level and reinforce skills/lessons taught in school, therapy, etc.

- **Respite Services** – are provided on a short-term basis in the absence of, or for relief of, those persons normally providing care.

- **Clinical Support** – is provided to individuals receiving services from DDDS as dictated in the care plan. These services might include, but are not limited to: psychological, nursing, occupational, physical, and speech therapies.

4. Program of All-Inclusive Care for the Elderly (PACE)

Expected to be available in the Fall of 2012 in New Castle County

This program provides comprehensive community-based care and services to people who meet nursing home level of care as defined by Delaware Medicaid criteria. This program also requires individuals to: live within the specified PACE service area; be 55 years of age or older; and live safely in the community with the appropriate supports and services at the time of PACE enrollment.

PACE provides all services covered by Medicare and Medicaid as determined necessary by the PACE health care team. It also covers other services necessary to keep individuals in the community if those services are part of the care plan developed by the PACE health care team.

Samplings of these services include:

- Primary Care (including doctor and nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Emergency Services
- Home Care
- Physical Therapy
- Occupational Therapy
- Adult Day Care
- Recreational Therapy
- Meals
- Dentistry
- Nutritional Counseling
- Laboratory/ X-Ray Services
- Social Work Counseling
- Transportation

What are the steps to receive Medicaid payment for Delaware long-term care services?

Step 1	Medical eligibility
Step 2	Financial eligibility

How do I begin the process for Medicaid payment for long-term care services?

First a referral must be made (usually by telephone).

For **Developmental Disabilities Services Waiver** call the Division of Developmental Disabilities Services (DDDS).

DDDS	Statewide	302-744-9600

For all other Long Term Care Programs, call the Division of Medicaid & Medical Assistance (DMMA) **Central Intake Unit**.

1-866-940-8963

Notes/Questions:

STEP 1 MEDICAL ELIGIBILITY

- Upon receiving a referral for the Nursing Facility, or Long-Term Care Community Services, a nurse may visit the applicant to determine if he/she requires a skilled or intermediate level of care as defined by Delaware Medicaid criteria. Some Medical determinations can be made by obtaining information from the nursing home. The PAS RN will make this determination.

- Medical eligibility for the Developmental Disabilities Services Waiver is initiated by the Division of Developmental Disabilities Services and is determined by a Medical Review Team within the Division of Medicaid & Medical Assistance.

STEP 2 FINANCIAL ELIGIBILITY

- The DMMA Central Intake Unit will send an application packet to the applicant or family contact. The person receiving the packet is instructed to call their local office or the DMMA Central Intake Unit for an appointment with a financial eligibility social worker.

- The applicant or family contact should complete the application prior to the interview but not sign the application. All information relating to the application should be brought to the interview so that an accurate and timely determination of eligibility can be made. If the social worker needs further documentation, a letter will be given to the applicant or family member stating what items are still needed.

- Once all the information has been received, and if the applicant is determined to be medically and financially eligible, the start date for Medicaid coverage of long-term care services will be determined based on the date of placement in a nursing facility or the date approved for community-based services in the home.

THE INTERVIEW

What should I bring to the interview?

Bring documents verifying the applicant and his/her spouse's income and resources to the application interview. The documents will be photocopied for the applicant's record. All positive responses on the application will need to be verified (bank statements, trusts, annuities, etc). Do not wait until you have all the documents before scheduling the interview. If you have difficulty obtaining some of the information, your DMMA social worker can offer suggestions for other sources or ways of obtaining the necessary verification. The following is a list of typical items that may be requested to determine eligibility. Please bring all available items to the interview:

Requested Verifications for Applicant and Spouse

- □ Birth certificate or INS alien forms/cards
- □ Proof of identity (photo ID)
- □ Social Security card
- □ Marriage certificate or divorce decree
- □ Power of attorney or guardianship papers
- □ Health insurance cards
- □ Proof of health insurance premiums
- □ Titles to all cars/motor vehicles
- □ Copies of all income checks or current award letters such as Social Security or pension checks
- □ Financial account statements (CD, money market, checking, savings, credit union, Christmas Club, IRA, etc.)
- □ Annuities (complete contract and supporting documentation)
- □ Trusts (trust document and financial accounts)
- □ Bonds or stock certificates
- □ Deeds to any property in the applicant or spouse's name
- □ Contract for prepaid burial
- □ Life insurance policies where the applicant or spouse is the owner
- □ Any other resource or income information

Notes/Questions:

Financial Eligibility Determination

What determines if an applicant is financially eligible for Medicaid payments for long-term care services?

- The applicant's monthly **gross** income must be less than **250%** of the Supplemental Security Income (SSI) standard after certain deductions are made. Each applicant will have $20.00 of his available income disregarded in order to determine his/her eligibility. A couple applying for Medicaid receives one $20.00 disregard from their total combined income.

- For applicants who have earned income the following disregards apply to the monthly gross earned income:

  Deduct $20.00
  Deduct $65.00
  Then ½ of the remainder

- Contact your local Long Term Care unit for current income limits.

- The applicant's liquid resources must be $2,000.00 or less. Liquid resources are items such as bank accounts, stocks or bonds, etc. The applicant is also allowed to put aside $1,500.00 for burial expenses.

- The applicant must be a Delaware resident.

- The applicant must be a U.S. citizen or lawful alien admitted for permanent residency.

- The applicant must be willing to enter a nursing facility voluntarily, or accept services through the Long-term Care Community Services program voluntarily.

Notes/Questions:

Resource Eligibility

What is counted as a resource?

Property – Property, such as houses or land owned solely or jointly by the applicant would be considered his/her resource, with some exceptions:

- If the property is still occupied by a spouse, dependent adult or adult child who has cared for the applicant, it may be excluded.
- If the applicant intends to return to his/her home and is competent to state such in writing, the property may be excluded.
- If the property is income-producing, such as rental property, in some specific cases it can be excluded.

If the property does not meet any of the above situations, it may need to be sold at Fair Market Value and the proceeds used to pay for the applicant's care. The applicant may be eligible while the property is being sold, as long as certain conditions are met. Upon the applicant's receipt of the money from the sale of the property, the Medicaid case will close. When the money from the sale of the property is exhausted, the applicant may reapply.

Vehicles

- The fair market value of any cars owned solely or jointly by the applicant or spouse would be counted as a resource. Other motor vehicles such as motorcycles, boats, trailers, etc. would be counted at fair market value. One car may be excluded if it meets certain provisions for its use.

Liquid Assets – Any liquid asset owned solely or jointly by the applicant will be considered to belong entirely to him/her, unless proof is provided to show ownership by another person.

- The current value of any stocks or bonds would be considered a resource.

- The current balance of any certificates of deposit, money market accounts, retirement accounts, or checking or savings accounts would be considered resources.

Burial Arrangements

- An applicant can set aside $1500.00 for burial.

- Money paid to a funeral home to purchase burial space items including the casket, the vault, the opening and closing of the grave, and the burial plot would not be considered as a resource.

- An irrevocable burial trust up to $10,000.00 may be established and will not count as an available resource.

Pre-Arranged Funeral Agreements – If the applicant has any type of funeral agreement and other burial resources, such as life insurance or an account set aside for burial, they both may count towards the total resource limit.

- If the applicant has a pre-need funeral agreement that is considered to be irrevocable for Medicaid purposes, its value counts towards the $1,500.00 burial allowance, providing certain provisions are met.

- If the applicant has life insurance which funds an irrevocable funeral contract, it also counts toward the $1,500.00 burial allowance.

- If the applicant has a pre-need funeral agreement that is revocable, the burial space items (see above) are excluded and the remainder counts towards the $1,500.00 burial allowance.

Life Insurance

- If the face value of combined life insurance is $1,500.00 or less, it is excluded.

- If the face value of combined life insurance is more than $1,500.00, the cash surrender value is considered a resource. If the life insurance policy is designated for burial purposes, $1,500.00 of its value may be excluded under the burial exclusion.

Other resources – The prior categories of resources take into account most examples; however, other resources may also be counted. The financial eligibility social worker will assist you at the time of your initial interview and will discuss Medicaid policy and how Medicaid may consider certain resources. In cases with trusts or other legal instruments, the type of resource may have to be discussed with the policy administrator to determine how Medicaid policy would apply. Each case is considered based on its unique set of resources.

Income Eligibility

How is monthly income determined?

- An applicant's total gross income received on a regular basis, such as monthly or quarterly is added together. Some examples of income are: Social Security benefits, wages, Veteran's benefits, pensions, annuities, and interest income.

What if my gross monthly income is more than the current Medicaid income limit?

- An amendment to Medicaid law allows the exclusion of income if the funds are placed upon receipt in an income qualifying trust, called a Miller Trust. This trust allows those persons who are over the current Medicaid income limit to set up a trust so that they may become income eligible. These trusts must be irrevocable, and you would need to contact a lawyer before beginning the application process for Medicaid.

Transfers

How does Medicaid look at resources that have been transferred or given away?

Individuals applying for one of the Long Term Care Medicaid programs may be disqualified from payment of Long-term care services if they transfer resources for less than their fair market value during or after the 60-month period immediately prior to the date of their Medicaid application. The difference between the compensation received and the resources' fair market value is considered in determining how long the applicant could be ineligible for payment of Long-term care services.

Exempt Transfers

The transfer of resources rule does not apply and payment of long-term care services is not affected if the title to the individual's home was transferred to the individual's:

- Spouse
- Child who is blind, disabled, or under the age of 21
- Brother or sister who has equity in the home and has been living there for at least one year before the individual was admitted to a nursing facility or
- Adult son or daughter who has been living in the home and providing care that delayed the individual's admission to the nursing facility for at least two consecutive years.

Substantial Home Equity

Individuals will not qualify for Long-term Care Medicaid payments if the equity of their primary residence is more than $525,000.00.

This rule does not apply if the primary residence is occupied by:

- A spouse
- A dependent child under age 21 years, or
- A blind or disabled child of any age.

Spousal Impoverishment

How does Medicaid consider a married couple's resources and income?

Effective September 30, 1989, legislation (Section 303 of the Medicare Catastrophic Act) was passed to change the way Medicaid calculates a couple's resources so that the community spouse would not become impoverished. This policy allows for resources and income allowances for the community spouse. To be considered as a spousal impoverishment case, one spouse must be institutionalized or planning to be institutionalized and one spouse must be living in the community.

Community Spouse's Income

Income received by the community spouse is not counted when determining income eligibility for the applicant. The community spouse's income is counted when determining how much of the applicant's income will be set aside for the community spouse's monthly household expenses (monthly maintenance needs allowance).

Spousal Impoverishment Resources

Under the 1989 legislation, Medicaid counts all of the couple's resources together (everything owned by one or the other spouse, and all the jointly owned resources) to determine a case total.

If the case total is less than $27,000.00, the applicant may be found eligible for Medicaid.

If the case total is above $27,000.00, the total is split in half, with half attributable to the community spouse and half to the applicant spouse.

If the community spouse's half is less than $25,000.00, an amount may be taken from the applicant spouse's portion to bring it up to $25,000.00.

If the community spouse's half is more than the maximum Protected Resource Allowance, the excess is attributable to the applicant spouse and would have to be spent on his/her care.
Note: This amount changes annually. Please contact your local Long Term Care office for the current amount.

A calculation summary and a target amount for the case total will be given to the applicant. When the case total falls within the limits, the applicant would have to reapply.

Notes/Questions:

For more information or any questions about Medicaid Long Term Care Services please contact your local Long Term Care Medicaid Unit.

Central Intake Unit
866-940-8963

Wilmington
Long Term Care Financial Unit
910 East 16th Street
Wilmington DE 19802
302-577-2174

Newark
Long Term Care Financial Unit
153 East Chestnut Hill Road
Newark DE 19713
302-368-6610

Smyrna
Long Term Care Financial Unit
200 S. DuPont Blvd, Suite 101
Smyrna, DE 19977
302-514-4560

Dover
Long Term Care Financial Unit
805 River Road
Dover, DE 19901
302-857-5070

Milford
Long Term Care Financial Unit
253 NE Front Street
Milford DE 19963
302-424-7210

Georgetown
Long Term Care Financial Unit
546 S. Bedford Street
Georgetown DE 19947
302-856-5379